COMMUNITY ARTS AGAINST ANTIBIOTIC RESISTANCE IN NEPAL

FACILITATORS' MANUAL

A facilitators' guide to designing, facilitating and learning from participatory creative approaches to help find community-led solutions to Antibiotic Resistance.

THE CARAN PROJECT

This manual has been developed as part of the CARAN project; Community Arts again Antibiotic Resistance in Nepal.

CARAN was a practice-research project that took 2017-19 in Nepal. It was co-funded by the UK Arts and Humanities Research Council and the UK Medical Research Council via the Global Challenges Research Fund. The project and resulting manual were co-devised by CARAN's multidisciplinary team based across University of Leeds' Nuffield Centre for International Health & Development (UoL Nuffield) and Centre for World Cinemas & Digital Cultures (UoL CWCDC) and Nepali research and policy organisation HERD international. The project was led by Professor Paul Cooke (Principal Investigator), Dr. Rebecca King (Co-Investigator) and Sushil Baral (Co-Investigator).

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LIST OF ABBREVIATIONS

ABR	Antibiotic Resistance
CHW	Community Health Worker
F1	Facilitator 1
F2	Facilitator 2
FCHV	Female Community Health Volunteer
PV	Participatory Video
VAHW	Village Animal Health Worker
WHO	World Health Organisation

FILMMAKING GLOSSARY

B-Roll	Footage that is shot to provide context for an interview.
Cutaways	Footage that is taken from the b-roll to cover up jump cuts and to build context into the interview.
Jump cut	A jarring cut that occurs when interview footage is edited to take out the parts that you don't want to include in the film.
Shooting script	List of shots that the filmmaker needs to get.
Film treatment	An overview of the content of the film.
Paper edit	Rough list of the shots that the community want included in the film.
5-shot sequence	A filming technique that uses five different shots to depict an activity

PROJECT OVERVIEW, GUIDING VALUES & HOW TO USE THE MANUAL

WHAT IS CARAN?

The CARAN project was born out of a collaboration between public-health professionals, health education facilitators, participatory filmmakers, and creative arts practitioners, with research backgrounds in medicine, anthropology and the humanities. It is funded by the UK's Arts and Humanities and Medical Research Councils. The reason for bringing such a diverse group together to help tackle antibiotic resistance in Nepal is a desire by all partners to find ways of better connecting policy-level decision making with the reality of those people living in affected communities. Our objective is to explore how participatory approaches can help ABR-related policy both better inform and be informed by the people whom it seeks to affect.

In Nepal, antibiotic-treatable infections are a significant public health burden. A recent review of studies examining antibiotic resistance to common bacterial diseases in Nepal states that 'in credible studies, more than half of Escherichia coli, Klebsiella pneumoniae and Streptococcus pneumoniae isolates tested […] were resistant to first-line antibiotics', indicating that antibiotic resistance is a growing threat to public health there (Basnyat 2015: 6-10). The same report identifies six strategies for improving antibiotic use in Nepal: reducing the need for antibiotics; improving infection control and antibiotic stewardship; rationalising antibiotic use within the community; reducing the use of antibiotics in agriculture; educating health professionals, policy makers and the public on the sustainable use of antibiotics; and ensuring political commitment to the issue (ibid 10). Some limited progress is being made under each of the strategies, but major critical gaps remain. Public awareness and/or public education on AMR is highlighted in most international guidance and there is emerging understanding that 'grass-roots' community-level interventions are important in tackling AMR (Wellcome 2018[PC1]). Therefore, working with community stakeholders, in partnership with policymakers, we aim to understand barriers to preventing and controlling antibiotic resistance, to identify solutions to these barriers, and to advocate for sustainable changes to practice and policy to promote appropriate antibiotic use.

Combining arts-based approaches with science education to explore health issues in communities is not new. There have been a number of studies which discuss the advantages of combining these approaches to: a) empower participants to speak 'truth to power' and better understand the wider context of the issues that affect them and, crucially; b) to encourage health organizations and decision-makers to better understand and listen to communities whose personal experiences may bring new light and new ideas for solutions to the issue at hand.

This project differs from many arts-science projects in that, through its focus on participatory film, it seeks not only to engage participants and facilitators in creating new solutions to important issues, but also to actively involve and engage policy and decision makers throughout, from production to exhibition. The process is about building the confidence, knowledge and voice of a group of participants, but it is also about directly engaging key stakeholders and gatekeepers throughout the process in order that they might more actively engage in community-level discussion and action longer-term.

Central to all Participatory Research is the aim to bridge the gap between the academic researcher, project facilitators and community participants, in order to come to a collective understanding of the questions that a project is looking to investigate and a shared understanding of, and respect for, the particular knowledges that these different stakeholders bring with them. While there are always implicit power imbalances in these kinds of projects, perhaps because some members of a group have more authority within the community than others, or because funding for the project might have come from outside the community and might bring with it certain expectations, the success or failure of such a project invariably relies on building equitable relationships of trust.

This requires continual communication between participants and the repeated renegotiation of the project's terms of reference as the group's collective understanding of the issues at hand develop and change. In doing so, our project has always been careful to avoid generating outputs that flout the known facts about the issues at hand - for example, in this case, the science behind antibiotic resistance, on the one hand, or the cultural and economic realities of everyday life of community participants, on the other. The project was designed to be iterative in nature, with each iteration learning from the previous one. That said, each group the project worked with was also distinctive and so had to be worked with on its own terms.

METHODOLOGICAL APPROACHES

Born out of CARAN's project aims, this manual shares activities that combine the following methods:

PARTICIPATORY VIDEO

This method is at the heart of the project. Participatory video (PV) is generally seen, as Shirley White puts it, as 'a powerful force for people to see themselves in relation to the community', in order 'to empower people to shape their own destiny' (White 2003: 64). The starting point for much of the contemporary surge in PV activity is frequently traced to a community filmmaking project set up by the National Film Board of Canada in the mid-1960s to support the inhabitants of the Newfoundland island of Fogo in their efforts to avoid resettlement by the Canadian government. Filmmakers worked with the island's inhabitants to make films about their lives, the aim of which was, firstly, to raise awareness across the island of the shared nature of the inhabitants' plight. Here film became an extension of the way Benedict Anderson describes print media functioning in the Eighteenth and Nineteenth Centuries. The circulation of film images of, and by, the inhabitants of Fogo helped them to see themselves as part of a larger 'imagined community' with a collective purpose. Central to what became known as the 'Fogo Process' was critical self-reflection and collective discussion by the islanders of the images produced (Crocker 2003: 129).

Through the production, and more importantly their collective consumption of the films, participants claimed, Stephen Crocker suggests, that they gained in 'confidence [and] self-worth', developing, in particular, a 'better self-image' that valued their local knowledge. In turn, the 'Fogo Process' allowed this community, with its new collective sense of identity, to project itself externally in order to advocate (successfully) for change with the government (Crocker 2003: 130). The inhabitants remained and, indeed, many of those involved in the project still live on the island today. The Fogo Process was exported widely, and is frequently cited as the inspiration for many present-day projects (Crocker 2003: 123; Corneil 2012; Walker and Arrighi, 2012: 410; Bell 2017).

THE GOLDEN RULES OF PARTICIPATORY VIDEO

Be humble and respectful. We are lucky to be here.
Hand over control. Don't shoot any video until the rest of the group is comfortable with the camera and has had a go.
Always be aware of power dynamics. Between you and the group; between group members; challenging power dynamics without destroying group dynamics
Screen footage every day. The feedback loop is the secret to a good project.
Honour commitments and don't overpromise. Be clear about what participants can and can't expect from the project. No one is likely to become a film star through participation!
Make sure people can have their footage. If they want it and that they see/get copies of any films that are made.
PV is a process. It's about the participants not the facilitator. BUT the facilitator's knowledge and experience should be equally respected. And the product doesn't have to be rubbish. Participants should be encouraged to work on, and take pride in, their films.

PARTICIPATORY RESEARCH METHODS

Participatory research methods refers to a range of approaches and techniques to gather information during which the power is shifted from the researcher to research participants, in our case to the community members of the sites. Participatory research helps to bring the voices of those who are considered as voiceless or powerless more actively into the research. During the process, community members themselves / participants have the opportunity to analyse and reflect on the data they have collected and to draw out the conclusion of the research project, including thinking of possible solutions and actions for the problems identified. The CARAN approach uses participatory research techniques, particularly PV, to gather information around ABR from the community.

ARTS-BASED APPROACHES

Arts-based approaches refer to a range of activities, approaches and values that can be used to help support a participative, listen-first approach to community engagement. Arts-based approaches can originate from a range of art forms, including theatre, visual arts, literature and of course film, but they also encompass more general approaches to supporting and developing creative thinking. Much of this is rooted in the work of politically-engaged arts practitioners like Augusto Boal, who believed that the arts could provide a way for what he terms 'oppressed' communities to practice speaking truth to power in a safe space.

Arts-based approaches help to unpack a problem to develop strategies and plans for action, and in this way they contribute directly to developing the knowledge-base of the issue at hand – here, ABR. Primarily, however, their purpose in this project has been to build confidence, respect, listening skills, creative thinking skills and, crucially, positive and equitable partnerships between all participants and facilitators. Central to this process is making sure that activities are fun and open, helping to build a comfortable atmosphere where everyone can be involved and encouraged to experiment. Activities only work if they respect the people involved in the project and create a safe space in which everyone feels comfortable to speak, listen and be heard. In so doing (primarily through the 'unpacking issues' section below), these methods are aimed at creating a solid foundation upon which the group can tackle and discuss issues head-on and generate innovative, creative plans for their video projects together.

POLICY-FOCUSED ENGAGEMENT STRATEGIES

We have engaged with relevant stakeholders from the outset of the project in order to both generate awareness of this work locally and nationally and to ensure that it is aligned with national policy priorities and to ensure that we have taken an integrated approach to health systems strengthening. In practical terms this has involved developing advocacy activities that speak to the relevant local community actors, regional and national policy makers, including the national Ministry of Health and Population, and global health professionals.

OVERALL PROCESS

Central to this project approach is the use of PV as a tool both for research and for advocacy. The project begins with a series of workshops where facilitators and participants explore issues relating to ABR, as well as learning the basic principles of documentary filmmaking. Practicing filmmaking and exploring ABR take place together, the one being used as a tool to document and reflect upon the lessons learnt about the other. This is facilitated through the regular screening of footage shot by participants to participants in order to generate a strong feedback loop that allows participants both to reflect upon and improve their practice as filmmakers and to ensure the whole group understands the issues surrounding ABR as well as the specific challenges community participants face in using antibiotics appropriately. After a period of training, participants are then supported by the project facilitators to plan, shoot and edit their own films, engaging members of their wider community in the process.

Participants subsequently discuss how best to use the films as educational resources, on the one hand, and as advocacy tools on the other that can be used to raise awareness of the challenges they face in using antibiotics appropriately in order, firstly, to generate discussion at the community level about how these challenges might be overcome, and secondly, to raise awareness of these challenges at government level, helping participants to inform ABR policy and practice in Nepal.

KEY VALUES

Whilst there are times when one method leads in terms of project activities, the manual has been devised in such a way that the values and approaches of all these methods are combined throughout. To help clarify this approach here are some of the key values of the project.

KEY PROJECT VALUES

Building and sustaining equitable partnerships

Taking a listen-first approach

Adopting an ethical approach of continual informed consent, where all partners have a responsibility to be clear in their communication.

Ensuring that everyone has a clear understanding of the well-established issues surrounding ABR, so that no misinformation is propagated by the project.

Documenting everything.

MANAGING VERSIONS OF REALITY: SCIENTIFIC FACTS & COMMUNITIES

There are many indisputable facts known about antibiotics, antibiotic misuse and ABR. These are grounded in high quality scientific research. Communities and people also have their 'facts' or versions of reality that may or may not reflect accurate scientific facts.

This project had an ethical and moral responsibility to effectively and accurately communicate the facts that are known about antibiotics and antibiotic resistance and correct inaccurate information. However, this had to be approached in a way that supports and empowers participants. This allowed the project to focus on its main object, namely to probe and unpack local knowledge, attitudes, and practices that might both contribute to ABR and that might also have a role to play in developing community-led solutions to this issue.

FACTS MUST BE:

- KNOWN BY THE TEAM IN ORDER THAT THEY CAN DELIVER THIS RESPONSIBILITY.
- BASED ON THE HIGHEST QUALITY SCIENTIFIC EVIDENCE AVAILABLE.
- REFERENCED SO THERE IS DOCUMENTARY EVIDENCE OF WHERE THEY WERE SOURCED.

FACILITATORS NEED TO:

Converse with stakeholders

Communicate facts

Correct misinformation, false truths etc.
Behave ethically

Produce films and other outputs that communicate accurate information (or present inaccurate information in a manner that makes it clear it is inaccurate)

Promote behaviour that reduces antibiotic misuse and antibiotic resistance in humans and animals

COMMUNICATING FACTS: KEY PRINCIPLES

Facts should be communicated in a manner that is appropriate for the audience e.g. layman's terms may need to be developed for community work

Incorrect or inaccurate information that comes up in conversations, community work or filmmaking should be politely challenged and corrected. There may be circumstances where it is hard to challenge or correct, for example, if someone is getting angry. In other circumstances, people may not believe you. It may be helpful to have written information available that you can leave with them in these circumstances.

Project outputs, such as films, leaflets or journal articles can use inaccurate information as part of the community-led discussion process, but it is essential that the correct facts are presented and that the inaccurate information is highlighted as inaccurate. For example, a clip of someone saying that 'humans become resistant to antibiotics' might be presented as part of a film in order to generate a discussion on 'commonly-held myths' about ABR. However, it should always be accompanied by factual information highlighting the scientific perspective, namely that bacteria become resistant to antibiotics rather than people and that 'humans becoming resistant to antibiotics' is not correct.

INTRODUCTION TO THE MANUAL

AIMS OF THE MANUAL

The aim of the manual is to provide facilitators with a solid foundation in how to run a programme of workshops designed to support delivery of the project's overall aims. It is foundational, consequently, facilitators should feel free to adapt activities to the specific needs of the group they are working with and building on their own expertise. The values of the programme, however – especially its participatory nature and its commitment to dispelling myths and avoiding spreading misinformation about ABR – should be maintained throughout.

The manual is designed to provide facilitators with all the support required during the planning and delivery of the workshops. It does not, however, replace the value of practical training and we strongly encourage users to attend a train-the-trainer session where possible, in order to experience the activities first-hand before using them themselves. The manual is not intended to be a detailed overview of ABR, and users should always consult the World Health Organization website and other resources for detailed information and advice relating to ABR, which may have moved on since this manual was written.

THE MANUAL AS A LIVING DOCUMENT

This manual is intended to be a living document, rather than a 'one size fits all' piece of guidance. Because of the particularities of each group of participants involved, and the differing areas of expertise of each practitioner who chooses to use it, we are keen to build up a bank of different approaches and feedback of the activities as the project continues, for example by adding alternative exercises for different contexts. If you would like to add any suggestions to this document, please contact the team by emailing ce4amr@leeds.ac.uk

AN OVERVIEW OF ANTIBIOTIC RESISTANCE

WHAT ARE BACTERIA?

Bacteria are some of the smallest forms of life. They are too small to see with the human eye. They live all around us (including in the soil, air and water). Millions live in and on our bodies. Most are not dangerous to humans and many keep us healthy such as gut bacteria that help us digest food. Less than 1% make us sick. Diseases caused by bacteria include tuberculosis, tetanus, cholera, diphtheria, gonorrhoea and urinary tract infections.

WHAT ARE ANTIBIOTICS?

Antibiotics are drugs used to prevent and treat infections caused by bacteria in humans and animals. Depending upon their type, they work by either killing the bacteria or stopping their reproduction. When clinically-appropriate, antibiotics must be used to cure bacterial infections in humans and animals. This prevents morbidity (ill-health from the infection) and mortality (death), both for the affected individual and to prevent the spread of infectious disease and thus morbidity and mortality to others. A large proportion of antibiotics taken by humans and animals pass through their systems unchanged and then enter the environment.

WHAT IS ANTIBIOTIC RESISTANCE?

ABR occurs when bacteria become resistant to antibiotics. I.e. the antibiotics are not effective against them. Some people mistakenly think that people or animals become resistant to antibiotics when in fact it is the bacteria themselves that become resistant.

HOW DO BACTERIA BECOME RESISTANT TO ANTIBIOTICS?

There are three mechanisms that enable bacteria to become resistant to one or more antibiotics:

- **Some bacteria have natural resistance against certain type of antibiotics.**
- **Some bacteria develop resistance through their genes mutating.**
- **Some bacteria acquire resistance from other bacteria by sharing genes.**

These mechanisms occur naturally but the use of antibiotics speeds up this process by applying 'selective pressure'. When bacteria resistant to a particular antibiotic come into contact with that antibiotic they are no longer killed. Over time, these resistant bacteria become more common whilst the non-resistant bacteria, which are killed off by the antibiotic, become less common. Thus the use of antibiotics increases the 'selective pressure' and promotes the survival of resistant bacteria. As resistant bacteria reproduce, their offspring have the same resistance genes.

WHAT ARE THE CONSEQUENCES OF ANTIBIOTIC RESISTANCE?

When bacteria become resistant to a certain antibiotic, the antibiotic is no longer effective against the bacteria. This means that the infections caused by resistant bacteria may be harder to treat or – in a worst case-scenario – not treatable. Therefore, people will experience more ill-health or even death from infections which were used to be treated by the antibiotics before the bacteria became resistant. They will have to stay longer in hospital, pay higher health costs and experience greater consequences of ill-health, such as loss of earnings. Some procedures, such as caesarian sections or surgery; some illnesses such as immunosuppressive diseases e.g. HIV; and other treatments such as renal transplants or chemotherapy will become much more dangerous without effective antibiotics to prevent or treat infections.

THE IMPORTANCE OF ADDRESSING ANTIOBIOTIC USE, MISUSE/ABUSE, AND ANTIBIOTIC RESISTANCE

Tackling antibiotic misuse/abuse and ABR are global priorities. They are some of the biggest threats to global health, food security and development. ABR is rising to dangerously high levels in all parts of the world. It can affect anyone, of any age, in any country. Given the ease and frequency with which people now travel, ABR is a global problem, requiring efforts from all nations and all walks of life. ABR is a major problem now and will get worse if it is not addressed. We all have a responsibility to think about and address ABR. We know that certain behaviours and circumstances makes the situation worse:

CONTRIBUTORS THAT EXACERBATE ANTIBIOTIC RESISTANCE:

- MISUSE, OVERUSE AND UNDERUSE OF ANTIBIOTICS.
- AVAILABILITY OF ANTIBIOTICS FOR HUMAN OR ANIMAL USE WITHOUT PRESCRIPTIONS.
- LACK OF STANDARD TREATMENT GUIDELINES, LEADING TO OVERPRESCRIBING BY HEALTHCARE WORKERS AND VETS AND, AS A RESULT, OVERUSE BY THE PUBLIC.
- LACK OF KNOWLEDGE ON ABR IN THE PARAPROFESSIONALS AND PHARMACY STAFF POOR INFECTION PREVENTION AND CONTROL MEASURES

WORLD HEALTH ORGANISATION GUIDANCE ON REDUCING THE IMPACT OF ANTIBIOTIC RESISTANCE

The World Health Organisation has identified steps that all levels of society can take to reduce the impact and limit the spread of resistance:

INDIVIDUALS CAN:

WHO Guidance

- Only use antibiotics when prescribed by a certified health professional.
- Never demand antibiotics if your health worker says you don't need them.
- Always follow your health worker's advice when using antibiotics.
- Never share or use leftover antibiotics.
- Adopt preventive health care practices to prevent infections by regularly washing hands, preparing food hygienically, avoiding close contact with sick people, practising safer sex, and keeping vaccinations up to date.
- Prepare food hygienically, following the WHO Five Keys to Safer Food (keep clean, separate raw and cooked, cook thoroughly, keep food at safe temperatures, use safe water and raw materials) and choose foods that have been produced without the use of antibiotics for growth promotion or disease prevention in healthy animals.

POLICY MAKERS CAN:

WHO Guidance

- Introduce the legal basis (provisions) for the restricted and judicious use of antibiotics in human and animals.
- Ensure that a robust national action plan to tackle antibiotic resistance is in place.
- Improve surveillance of antibiotic-resistant infections.
- Strengthen policies, programmes, and the implementation of infection prevention and control measures.
- Regulate and promote the appropriate use and disposal of quality medicines.
- Make information available on the impact of antibiotic resistance.

HEALTH PROFESSIONALS CAN:

WHO Guidance

- Prevent infections by ensuring their hands, instruments, and environment are clean.
- Only prescribe and dispense antibiotics when they are needed, according to current guidelines.
- Report antibiotic-resistant infections to surveillance teams.
- Talk to patients about how to take antibiotics correctly, antibiotic resistance and the dangers of misuse.
- Talk to patients about preventing infections (for example, vaccination, hand washing, safer sex, and covering nose and mouth when sneezing).

THE HEALTHCARE INDUSTRY CAN:

WHO Guidance

- Invest in research and development of new antibiotics, vaccines, diagnostics and other tools.

THE AGRICULTURE SECTOR CAN:

WHO Guidance

- Strictly regulate and discourage the use of antibiotics in animal feed, ensuring this is strictly monitored.
- Only give antibiotics to animals under veterinary supervision and make sure that the withdrawal period is strictly adhered to.
- Not use antibiotics for growth promotion or to prevent diseases in healthy animals and birds.
- Vaccinate animals to reduce the need for antibiotics and use alternatives to antibiotics when available.
- Promote and apply good practices at all steps of production and processing of foods from animal and plant sources.
- Improve biosecurity on farms and prevent infections through improved hygiene and animal welfare.

PROJECT SET UP

PARTICIPANT RECRUITMENT PLAN

In this section we describe in detail how we went about setting up and delivering the CARAN project. Some of this work was specific to the particular context in which we were working. However, the general questions raised are always important in these sorts of projects. So we have also tried to frame our presentation of the project with the key questions that we felt we needed to address in our approach.

THE VALUE OF PRETESTING

Once you have tailored your workshop approach to your own context and, ideally, participated in a 'train-the-trainer' session on the approach, we strongly encourage the facilitators to pretest activities before delivering them with their selected groups, bearing in mind that each group experience will be different. Also, the pre-test will assist the facilitators in identifying strengths and challenges that can be adopted during the actual activities. The pre-test can be conducted anywhere other than the study sites.

SITE SELECTION

What We Did

Initial coordination was conducted with the municipality officials and a half-day meeting was organized with key stakeholders (the mayor, deputy mayors, ward chairs as relevant and other key persons). The purpose of this meeting was to conduct initial coordination and to sensitize the stakeholders to the objectives, methods and the processes of the study. A letter from the implementing organization was provided to the municipality office requesting their support in the study.

Since the municipality is a wide area to cover, specific areas within the municipality for the study were selected. This we discussed with the stakeholders, and agree specific area/boundaries where the project activities would be conducted. We were keen to have agricultural activity (farming and animals), as well as pharmacies present in the chosen locations.

GATE KEEPERS

What We Did

To identify the relevant gate keepers, we first listed the possible gatekeepers in discussion with key informants in the municipality or ward office such as mayor, deputy mayor, information officer, ward chair and alike.

The list of possible gatekeepers was updated after visiting the community, in discussion with key community members. We then visited the most relevant gate keepers and explained to them the objectives, methods and processes of the study, as well as their roles and responsibilities in the study, before asking them if they would like to participate. 2-3 relevant gate keepers from different backgrounds, who could provide consent and time to participate in the study were selected for each site. A half-day discussion meeting was conducted with the identified gate keepers to conduct initial coordination and discuss the project and their involvement in more detail.

Gate keepers are central to the project.

They are the key personnel liaising with facilitators in order to connect them with the community participants. Their major role is identification, coordination and liaison with the study participants as needed throughout the project. Keep the following critera in mind when listing possible gatekeepers:

- Gate keepers should belong to the same community and should know the community well.
- They should be a recognized person in the community.
- Gate keepers could be from a different background. For example, a gatekeeper might be a FCHV, someone engaged in agriculture and animal farming, a pharmacist, a key leader, a school teacher and so on. Since we planned to have a diverse group of participants in the workshops, having diverse gate keepers was identified as a way of helping to coordinate a diverse group of participants.

What is the geographical scope that you are looking to have in your project? How many stakeholders do you need to engage with in each community?

Do you know who the local decision makers and gatekeepers are in the communities in which you want to work? Could there be key stakeholders you are not yet aware of? Who do you need to speak to in order to learn more?

Do you have a one-page summary of the project aims, objectives, methods and processes that will make sense and feel relevant to the stakeholders with whom you want to engage?

Are there any local decision makers or community gatekeepers who might have resistance to the project? Who do you need to speak to in order to get them on side or avoid delays?

IDENTIFICATION & SELECTION OF PARTICIPANTS

What We Did

8-10 participants were identified from each community. We worked with as diverse a group of participant as is possible, given the specificities of each community, with the aim of generating a diversity of views on antibiotics use and misuse.

Gate keepers identified and prepared a list of possible participants. Relevant participants from the list prepared by the gate keepers were then visited. Also, the facilitators adopted a snowball technique to identify and list other eligible participants through the identified participants (if gate keepers could not identify enough relevant participants, or those identified could give time to the study). During the visit, the objectives, methods, and process of the study were explained to participants, along with their roles, duration of participation, as well as the risks and benefits of participating. In providing this information, we sought their voluntary consent for participation in the study.

Which targe groups do you need to include in your participant groups? Think about:

- Users / non users of antibiotics including farmers
- Pharmacists including vet pharmacists / agro-vets
- Any provider of medicines / antibiotics
- Community leaders
- Community health workers (CHWs)/ female community health workers (FCHVs) in Nepalese context

Be mindful of diversity and inclusivity issues when it comes to age, gender, ethnicity, literacy levels.

CONSENT FROM PARTICIPANTS

What We Did

After the identified workshop participants had been visited and briefed about the study, a written consent form was signed by each participant. It is important for facilitators to clearly explain why, how and where the photos and videos of the participants will be used and how they can decline to make these public if they do not wish them to be.

For those community people who would be approached by the workshop participants to be a part of the films that were to be produced by the project, it was also equally important to seek their consent. On screen video consent was sometimes adopted in this case, instead of written consent (if people were, for example, only briefly interviewed as part of a 'vox pop'). These participant were, however also briefed about the study and its objective by the workshop participants and were also informed how they could withdraw their consent after the interview, if required.

WORKSHOPS

What We Did

Those individuals providing written voluntary consent were then invited for the workshops. The time and venue for the workshops was be agreed through discussion with the participants. There were 5 workshops in each iteration of the project. All 5 workshops were conducted with the same group of participants. The length of the workshops varied, flexibility needing to be adopted to take account of the availability of participants and how quickly they were able to complete the various activities taking place in each.

What might you need to talk about with your participant group to find a time, location and structure that works for them?

Think about and consult your participants regarding:

- Their work, childcare, domestic and religious commitments
- Whether you need to offer a meal as part of the workshop (our groups preferred to participate before work so we provided breakfast)
- Which venue is a neutral space for all community members
- How much time they can give a day and at what frequency

OVERALL WORKSHOP PROGRAMME

Before planning for pre-tests or actual workshops, it is important for facilitators to know the objective of each activity and how it fits in with the broader framework of the project

In this programme there are five workshops, each with a specific focus and each contributing different skills, knowledge and experience to the project. These are used as the foundation for the subsequent community-focused filmmaking stage.

WORKSHOP ONE: INTRODUCING THE PROJECT, FILMING EQUIPMENT AND SHOOTING PROFESSIONAL-LOOKING FOOTAGE

- **Activity 1:** Introducing the Project
- **Activity 2:** Introducing Filming equipment and Shooting Professional-looking Footage

WORKSHOP TWO: UNPACKING THE ISSUES

- **Activity 1:** Where do I Stand 'Maile Ke Sochchu'
- **Activity 2:** Storytelling... 'And So....': 'Ani Tespachi'
- **Activity 3:** Identification of Key Characters/Stakeholder**s**
- **Activity 4:** Hotseating
- **Activity 5:** Reflection & Discussion of Interview Footage from Wshop 1

WORKSHOP 3: INTRODUCTION TO GENERAL DRUGS AND ABR AND LEARNING OF INTERVIEWING TECHNIQUES

- **Activity 1:** Playing Corner, Introduction to General Drugs, Antibiotics and its Resistance
- **Activity 2:** Shooting B Roll, 5 Shot Sequence and Interviewing with the New Techniques

WORKSHOP 4: CONSOLIDATING KEY CONTENT AND IDENTIFYING THE KEY LOCAL STAKEHOLDERS

- **Activity 1:** Mind-mapping (Local Context)
- **Activity 2:** Critical Reflection on WHO guidance
- **Activity 3:** Reflection and discussion of the Interview Footages from Workshop 3

WORKSHOP 5: DEVELOPING YOUR FILM IDEAS

- **Activity 1:** Scriptwriting
- **Activity 2:** Crafting your film treatment
- **Activity 3:** Writing your shooting script

WORKSHOP 1: INTRODUCING THE PROJECT

WORKSHOP 1 - ACTIVITY 1: INTRODUCING THE PROJECT

To introduce the project and the concept of community-led solutions

35 minutes

Projector, computer with power point presentation, projector screen

Learning by doing, reflection and discussion

3 sets of film equipment placed in different parts of the room

Capture the activity and document the process for evaluation

F1 Delivering and explaining the project and filming process. Helping create a fun and welcoming atmosphere.

F2 Responsible for documentation (film, notes, stills...). F2 to facilitate final discussion, at which point, F1 takes over documentation.

PROCESS

Set Up and general introduction of participants (15 minutes)

- Since it's the first day of the workshop, it might take time for participants to arrive on time and settle down
- Before introducing CARAN, F1 and F2 to quickly run through the introduction games and assure all the participants are involved in them. Facilitators are also responsible to bring participants and guests at ease while playing the intro games besides their diversity and hierarchy. Further, the facilitators should deliver instructions clearly before the games.

Introducing CARAN (20 minutes)

- After general introduction of the participants, F1 and F2 introduce the group to CARAN, drawing on the project outline above
- F1 to discuss what his/her/HERD/Leeds expectations of the project are, and to facilitate a discussion on what participants hope to get from the project (this will be developed further in the filmmaking exercises)
- F1 to facilitate a discussion to agree ground rules for participation (regular attendance, mutual respect, etc.)
- Note: This introductory discussion should last no more than 20 minutes, leaving more than an hour for the film exercises.

- **Try to put participants at ease, encouraging informal chats while waiting for everyone to arrive at workshops, not least because participants might not know each other.**
- **Make introductory games as informal and fun-filled as possible.**

WORKSHOP 1 - ACTIVITY 2: INTRODUCING FILMING EQUIPMENT AND SHOOTING PROFESSIONAL-LOOKING FOOTAGE

To allow the group to try out the cameras, tripods and sound equipment, learn some basic film theory and start to think about visual communication and interviews.

85 minutes

Cameras, tripods, sound equipment, projector, computer with power point presentation, projector screen, HDMI cable to connect cameras to the projector

Very short lecture followed by more learning by doing

3 sets of film equipment placed in different parts of the room. Initially, group to sit around projector screen.

Capture the activity and document the process for evaluation

F1 Running/Explaining the activities. F1 to keep the mood light.

F2 responsible for documentation (film, notes, stills...)

PROCESS

Introducing Filming Equipment (40 minutes)

- Participants divided into 3 separate groups in a different way to encourage mixing for smaller activities. Participants choose who they are comfortable working with
- F1 to introduce equipment one by one
- Each group asked to pick up a camera and figure out how to make it work.
- F1 asks the group to make sure everyone gets a go with the camera (F1 gives hints and guidance if people are struggling).
- Once each member of the group has tried the camera. The groups are asked to pick up a tripod and figure out how to fix the camera to it. (F1 to help as appropriate, and to ensure that the cameras are not dropped!)
- Once all the cameras are fixed, the groups are then asked to get the mics and asked to set them up. (F1 gives hints and guidance if people are struggling).

- **Try to reassure participants that it is ok to use the equipment and that it is hard to break!**
- **Make sure all the participants have a go on the equipment and mention that they will be the ones who will be making films using those equipment later**

Presentation on the basics (20 minutes)

- F1 runs through the 'Basics of camera, tripod and mics' and
- 'How to become a filmmaker in 5 minutes' Powerpoint Presentation, introducing participants to: How to start and end videos; Framing shots for interviews: The Rule of Thirds; Top tips for shooting and conducting interviews
- (A template presentation is available on the CE4AMR website).

Introducing Interviews (25 minutes)

- Groups work together to come up with a list of questions that they will ask to one or two of their members such as: why they are taking part in the project; what they hope to gain from it; what do they know about use of drugs?
- Group to decide who is going to be the camera person, who will be the sound person, ask the questions, making it clear that people can take on different roles over the course of the project.
- Set a time frame for interviews so that everyone can have a go at the different roles.
- Groups set up their video equipment and shoot 1 or 2 more interviews.
- Once the groups have completed their interviews, they give their cameras to F1

- **Encourage participants to take on different roles during the exercises so as to ensure that groups are flexible. This will be important during the filmmaking process later on.**

WORKSHOP 2: UNPACKING THE ISSUES

WORKSHOP 2 - ACTIVITY 1: WHERE DO I STAND? 'MAILE KE SOCHCHU'

To explore perspectives about general drug and antibiotic use; to build participants' confidence in voicing their opinion; to support listening skills and open thinking; to enable facilitators to identify gaps in participants' knowledge relating to ABR.

30 minutes

An 'object of truth' (an item that people are likely to understand as being generally connected to drugs and/or antibiotics), A list of statements related to both general health drugs and antibiotics

Game, group discussion

Open space with room for movement and Object of Truth and voice recorder in centre of room

Capture the activity and document the process for evaluation

F1 Being responsible for documentation (film, notes, stills...), while also engaging in the conversations.

F2 Ensuring different voices are heard within the group, along with F1

PROCESS

Set Up (15 minutes)

- It might take time for participants to arrive on time and settle down prior to starting where do I stand activity
- This time will be also used for providing quick review of workshop 1 and overview on activities to undergo

Where do I stand? (30 minutes)

- Participants stand in a circle.
- Explain what we're going to do now:
- The facilitator will read a series of statement
- After each statement, everyone moves closer to or further away from the 'objects of truth' depending on how much they agree or disagree with the statement.
- We'll then discuss people's opinions. People can change their position if they wish after listening to other people's points of view.
- Underline that this is not a knowledge test - these are not necessarily the facilitator's own point of view / nor are they 'right' or 'wrong' statements. Rather, they are designed to get us thinking about our own personal views about general drugs and antibiotic use where we live, and to listen to other people's views and how they might be similar or different from our own.
- Start the activity with an icebreaker statement (eg. Chocolate is tastier than sweets).
- You can use the list below as a starter. You can also add in or replace these with other statements depending on where the group discussion leads.

- Read out the icebreaker statement and allow people time to choose their position.
- Ask someone to explain why they chose to stand there / what they thought of the statement. (You can have a brief discussion and the group can respond but it should not be lengthy since it is an icebreaker).
- You can repeat this process with different members of the group 3-4 times. This ends discussion on icebreaker statement and will give participants sense of how the activity needs to be undertaken. Mention the participants that they would be introduced to actual statements now and before that introduce general drug and an antibiotics-related objects to the group.
- Pass the object around the group, encourage people to touch them, look at them etc.
- Open discussion as this happens – what do you think is? Do you recognize it? Etc.
- Explain the objects are going to be the 'objects of truth' and place them in the centre.
- Start with actual statement and repeat the process similar to icebreaker i.e. why they chose to stand there, what they thought about the statement and so on.
- Try to ensure everyone has had a chance to share their opinion at least once.

Examples of Statements

These should be formulated so that they are about the community, not about the participants, in order to create space for critical reflection. Probes are optional and should be based on the direction of discussion from the participants. For example:

- People are getting sick more often.
  - *Why did you stand where you are? What could be the main reasons for people to fall sick more often?*
- Some medicines are stronger than other medicines.
  - *Why did you stand where you are? How can you determine if a medicine is strong or not and which ones? How do you know what type of medicine you are using?*
- People prefer to go to the traditional healer when they are ill.
  - *What could be the main reasons to approach traditional healer and no other (especially medical personnel)? Would there be certain illnesses or disease that would make people seek traditional healers?*
- People often stop taking a medicine when they are feeling better.
  - *What could be the main reasons for people to stop taking medicine? Do you think that not taking the entire dose of medicines will affect our health or not?*
- People give medicines to animals and plants to help them grow more.
  - *Are you aware of any medicines? If so, which ones and why are they used? Do you think they will have any consequences on human health?*
- People generally use the same medicines for animals or plants as they do for humans
  - *Are you aware of any medicines that are used in human as well as animals? Why do you think same medicines are used for both? Where are these medicines available?*

- **Count how many participants choose to stand at which place. It will be useful for later analysis. For ease, codes could be written and clipped on paticipants' clothing visible for note taking eg. P1/P2/P3.**
- **Make sure the statements are short and simple for participants to understand easily.**

Potential challenges and Tips

Getting drawn into long conversations	This is designed as an introductory activity to touch on some of the main understandings, preconceptions, concerns etc. of the group. More in-depth discussion can then take place at a later stage.
Not overcorrecting people whilst ensuring misinformation is clarified	Notes should be made during the session by F2, and clarifying preconceptions etc. should happen after the session.
Keeping the pace moving and people engaged	Physical movement is key to this exercise. Keeping the activity short – 15 minutes max in total – stops people from getting tired and losing interest.
Confrontation between those of different opinions	Remind the participants that every individual have their own sets of opinions and are rightful to express them and we should respect that.
Misunderstanding of the topic, leading to a lack of confidence	This session should be more focussed on community responses to the 'Statements'. However, there might still be considerable need to ensure that facilitators have a good understanding of the community knowledge and opinions the participants wish to communicate, in the spirit of the discussion being rooted in the principles of 'equitable partnership'.
Person not wanting to participate in the activity directly	Try to encourage people to take part. If not then involve them in another way such as filming the activity.

WORKSHOP 2 - ACTIVITY 2: STORYTELLING: 'AND SO…' / 'ANI TESPACHI'

To explore typical stories related to drug use in different scenarios, to identify key characters/ stakeholders in community-level healthcare setting; to introduce the notion of storyline and creative development to the group; to build confidence in group work.

30 minutes

Small ball or neutral object (optional)

Game, group discussion

Sitting in a circle

Capture the activity and document the process for evaluation. Capture high-quality sound of the stories being told if not too invasive.

F1 Being responsible for documentation (film, notes, stills…)

F2 Facilitating the group discussion afterwards

PROCESS

Rules of the Game

- Participants are sat in a circle. One participant chooses a story theme (see below).
- Everyone must start their sentence with 'And So' ('Ani Tespachi' in Nepali)
- You must only say one sentence at a time.
- The story should always be told in the first person (I went to the doctors / My mother said…) – this helps to build a collective voice.
- Everyone must respect the direction the story is going in – do not try to negate what the person before you has decided to say (this is why we always use 'and so' rather than 'but' or 'however' etc.).
- If you don't know what to say or would like to miss a go, you can just pass the ball to the next person.
- People are allowed to have some time to think about what they want to say next.
- When it feels like the story has come to a natural pause, the story stops.

Process

- Participants sit in a circle and are explained the rules of the game. At this point, it might be important for facilitators to take more time for explanations to lead more rounds of 'storytelling'.
- Explain we are going to try telling a story (you might like to have a story bag where participants pick out a theme from the bag to start with). The group might also want to choose another story/theme based on appropriate themes (e.g. the farmers could work together to talk about animals being sick).
- Examples of themes: "One of your animals is sick"; "Your daughter has a sore throat", "Someone comes to visit your pharmacy" …

- Whoever starts the story should hold the small ball and then pass this onto the next person as the story continues.
- If the participants are facing difficulty in moving with the story, try to support them. If that doesn't work, show a short demonstration similar to pre-test.
- After you have completed the story, move on to the discussion phase. Talk through the story and make notes as you go – who were the main characters? What were the main issues? Did anyone think the story would/could go in another direction in real life?

- **Facilitators need to consider the themes carefully. The topics can be guided by the discussion of the previous exercise, with facilitators/participants developing what they considered to be particularly interesting strands in the earlier discussion.**

- **Opening statements should be kept relatively open. The aim of this exercise is to encourage participants to become more self-aware about the culture of drug use including antibiotics in their community, and how the issues raised relate to their own experiences. The issues should then be probed in more detail in the hotseating exercise below.**

During the discussion, F2 should carefully probe, in order to elicit attitudes, practices, and perceptions around drug use including antibiotics. The skill here is to probe these issues in a manner that intersects with the story, and in a manner that does not turn the activity into a focus group discussion! This discussion may well form the basis for the films the group ultimately choose to focus on. Areas to probe might include the following, which will be based on the story generated by the participants.

- Who do people ask for help when a person or an animal is sick, and why (probe around family members; neighbours / friends; informal healthcare providers; pharmacists; private healthcare providers; health facilities, including different staff and levels of facility)?
- In what order might people ask (the above) for help when a person or an animal is sick?
- If people consult a formal healthcare provider (let's probe the different types, i.e. pharmacists, private providers, facility staff, and for animals), under what circumstances are they given medicines?
- Do they know what type of medicines (probe antibiotics)?
- If they are given medicines / antibiotics, do the providers usually give them any advice about how to take them?
- If they are not given medicines / antibiotics, how do people react (e.g. do they accept, become angry, go somewhere else etc?)
- If they are given antibiotics, do they follow the advice given by the provider (probe, completing the dose, not sharing), and why or why not?
- If the problem is unresolved, what do they do?
- Note: If the issues come up, probe around infection control issues, especially hand-washing, vaccination, food preparation (for humans)
- For which conditions do the farmers mostly use antibiotics in animals/birds?
- Do they use feed that contains antibiotics? Do they know whether it does? Why do they use this feed? Is it just common practice? Is it to prevent infection? Is it to promote growth? Do they feel it works? Do they think there are any problems with this?

Potential challenges and Tips

People need to respect the rules for this game to work	Make sure you have clearly explained the rules before you begin and that everyone understands them. You can correct during the game if they aren't followed.
The story continues without progression	If the story has passed its moment of natural pause, as a facilitator you can step in. If a story runs into a dead end you can suggest passing it onto the next person, or getting someone else to start a new story.
People become upset through themes that are raised.	By telling the story as a collective it is unlikely that it will directly reflect a person's true memory.
People don't agree with the direction of the story.	Make sure you explore people's opinions of the stories – and other directions it might have gone in – as part of the post-activity discussion.
The stories result in stereotypes / the group reproduce stories they think we want to hear.	The collective telling should help draw in a range of experiences to avoid it becoming too entrenched in stereotype. Make sure you leave time in the discussion to consider what other directions the stories may have gone in, and if the group think this happens in real life or is just what people think happen.
Person not wanting to participate in the activity directly	Try to encourage people to take part. If not then involve them in another way such as filming the activity.

WORKSHOP 2 - ACTIVITY 3: IDENTIFICATION OF KEY CHARACTERS/ STAKEHOLDERS

To focus more closely on the different key characters/ stakeholders (which they may eventually wish to interview etc.) by encouraging participants to identify and express possible key characters beyond their comfort zones

10 minutes

Newsprint paper for listing the key characters/ stakeholders or Meta cards

Group discussion

Back to original positions

Capture the activity and document the process for evaluation

F1 Explaining the activity and being responsible for documentation (film, notes, stills...)

F2 Facilitating the group discussion afterwards

PROCESS

Group Discussion

- Depending on group size, this can be done as a whole group or in smaller groups. If it's the whole group, participants could be asked to list the possible characters while the facilitator can either jot down the list on paper that will be visible for everyone or request a participant to volunteer to make the activity more participatory. Whilst, if the group is divided into sub groups, each group will come up with a list of characters which will make participants brainstorm and one of them will volunteer to list them on cards later when requested. Further, these characters will be indicated by a representative from each group. This might aid in making the activity fun filled yet informative.
- Facilitators can help to shape this discussion, suggesting potential characters that would draw out appropriate issues. By this point, the participants will have begun to form opinions about the relevant issues in their community, and so these suggestions should operate as prompts for further discussion, rather than being considered too directive.
- Potential characters might include: Adult male, sick; Adult female, sick; Mother (parent) of sick child; Animal (think about categories e.g. those that are more social and economically valuable and those that are not e.g. cow and dog); Pharmacist/agro-vet; CHW (FCHV i.e. Female Community Health Volunteers); Healthcare provider in primary health care; Informal provider; Village animal health worker (or equivalent); Vet practitioners; JT/JTAs
- This activity functions as a follow-on to the 'And So' activity. It can precede the 'Hot Seating' activity depending on the nature of the group and time available. This is a very malleable exercise.

Potential challenges and Tips

People don't know how to begin	There are plenty of quick warm-up games that can be done to help people identify 'key characters'.
People don't want to take part in the 'speaking first' part	Crucially, try to encourage people to partake and keep key character identification phase of the activity light-hearted and positive. We are all a little apprehensive to try to speak first, but this is a good opportunity for people to venture into more creative activities in a safe space. They could be then involved in the hot seating activity.
People don't know what the final list should look like.	This is an activity which is best clarified through listing. Encourage the groups to keep trying identifying different characters and as a facilitator make sure you are engaging with the groups, providing ideas etc. where necessary whilst also respecting their ideas.
People stereotype the characters	Ensure that discussion also questions the approaches people have taken in a constructive way, asking whether they think this would apply to all, eg. mothers of ill children. If somebody else thinks the person would be different, they can always mention different characters and show their alternatives.

WORKSHOP 2 - ACTIVITY 4: HOTSEATING

To think from another stakeholders' perspectives, as well as exploring the experiences of those in the group from a safe distance; identify key themes that may become focus of the films; identify questions we don't yet know the answers to; develop technique and confidence in interviewing skills

20 minutes

None!

Drama game, character development

Individual seat designated as the 'hot seat' with others seated in front of it

Capture the activity and document the process for evaluation

F1 Explaining the activity and facilitating the discussion

F2 Ensuring all participants have an opportunity to engage

PROCESS

- After the key characters/stakeholders identification exercise, participants are invited to join voluntarily as the character/s for a hotseating exercise.
- You may not have time to hotseat each character, so decide as a group which ones you want to prioritise, based on the key topics that are emerging within the group.
- The person then sits on the hotseat and, in character, answers questions poised to them by the rest of the group.
- The facilitator should support the group where needed in the sorts of questions they ask (i.e. To keep on topic, to ensure respect across the group, to ensure only one question is asked at a time). The facilitator needs to be cautious here since the participants and hotseater/s might not know where to start from and what to ask and answer. In such cases, the facilitator can ask a few general questions to the hotseater/s to help them get into character and to make them comfortable enough to answer more detailed questions. A good and simple basis for this is just encouraging people to run through the big question words (Who / What / When / Where / Why /How). For instance:
    - Namaste! What is your name?
    - How long have you been working as a pharmacist?
    - Is this your own pharmacy?
    - Where did you train to be a pharmacist?
    - (And later build on questions such as)
    - Who do you think the antibiotics were for?
    - When do you decide that a patient is in need of antibiotics (rather than another drug)?
    - Why do you think people need clear prescription instructions?
    - How do you feel when you see a sick child/person arrive at your pharmacy?

- If anyone within the group thinks that the character would have answered the question differently to the way it was answered by the hot-seater, they can swap seats and take the hotseat, to also answer the question in that character. They can then remain as that character for more questions. Questions could be:
  - Would you do the same? Why? /Why not?
  - How?
  - Did you feel bad that……? What did you feel bad about or in particular? Why? / Why not?
- Open, facilitated discussion is encouraged where appropriate, but the group must wait for the character to finish their answer first before discussing it.
- The activity can continue with different characters taking the 'hot-seat'.

Potential challenges and Tips

The activity ends up in full open discussion	This is a good activity to employ listening skills, and also for those in the 'hot-seat' to feel a sense of being heard. Avoid the hot-seater being lost in an open discussion by keeping the questioning going, or – if somebody is making a recurrent point – encouraging them to go in the hot-seat. You could also take notes of key issues to return to later.
People are reluctant to sit in the hotseat	Normally, once one person has had a go people are drawn to this activity. If people are reluctant to start, F1/F2 could sit in hotseat and F2/F1 can ask few questions as short demo so that the participants can do it collectively later on.
People ask intrusive or inappropriate questions	As facilitator you should highlight any lack of respect from interviewers or characters – whilst this exercise is likely to have moments of humour, it is also practice for interviewing in the filmmaking process.
Too much chopping and changing	Whilst taking the hot-seat place of another helps to ensure everyone gets to be heard, too much of this and the activity loses its structure. Take care to manage this so that people have time to delve deeper into their own responses.

- Hot-seating is a flexible activity which can be adapted to the groups' needs. Additional resources around hotseating can be found here: https://dramaresource.com/hot-seating/ and https://demos.be/sites/default/files/games-for-actors-and-non-actors.augusto-boal.pdf
- Alternative activities might include a 1-2-1 iteration of this, working in twos, with one interviewer and interviewee who then swap roles. A group work approach is encouraged, however, for more open discussion.
- All of these activities are introductory, aimed at building the confidence of participants to value their own knowledge, while also introducing them to key issues around general drugs and antibiotics and developing the group's collective understanding of community attitudes to general drugs and antibiotics and what potential solutions might look like.

WORKSHOP 2 - ACTIVITY 5: REFLECTION AND DISCUSSION OF INTERVIEW FOOTAGE

To reflect on interview footage from workshop 1 and create a platform for further discussion

15 minutes

Projector, HDMI cable

Film screening and Group discussion

Participants sit facing the projector screen

Capture the activity and document the process for evaluation

F1 reflects interview footage via the projector.

F2 Facilitating the discussion

PROCESS

Each group discusses their interview, focusing not on the content but on the way the interview comes across (framing, focus, quality of sound etc.). The group discusses what worked and what could be improved. The group then should have a discussion about the content of the interviews. What kinds of questions worked and why? What was the relationship between the interviewer and the interviewee like?

WORKSHOP 3: INTRODUCTION TO DRUGS AND ABR AND LEARNING OF INTERVIEWING TECHNIQUES

WORKSHOP 3 - ACTIVITY 1: PLAYING CORNER AND INTRODUCTION TO GENERAL DRUGS, ANTIBIOTICS AND ITS RESISTANCE

To explore the participants' understanding of best practice on general drugs and antibiotics use; to introduce the issue and basic facts about general drugs, antibiotics and ABR that will form the basis of our work with communities

40 minutes

Cameras, tripods, sound equipment, projector screen, HDMI cable to connect cameras to the projector.

Short lecture followed by learning by doing, reflection and discussion.

Open space with room for movement; 3x film equipment sets across the room

Capture the activity and document the process for evaluation

F1 Delivering and explaining activities to be undertaken here. F1 to keep the mood light, making it clear that it's just fun and they will receive more guidance as the workshop develops.

F2 F2 responsible for documentation (film, notes, stills...). F2 to facilitate final discussion, at which point, F1 takes over responsibility for documentation. Both need a solid understanding of ABR facts and guidelines.

PROCESS

Set Up and Quick Review of Workshop 2 and today's activities (15 minutes)

Playing Corners (20 minutes)

- Each corner is given a number 1-4. Using the WHO quiz (see following page), F2 reads out each question, in turn. Participants choose the corner that corresponds to what they think is the right answer. After each question, F2 can facilitate a brief discussion 'were you surprised by that answer?' 'why?' etc.

- **Make the questions as short and simple as possible**
- **For this exercise it's helpful to use 'yes' or 'no' questions, to keep the discussion of the 'science' clear.**

QUIZ QUESTIONS

1. How do you think bacteria infections are caused?
   a. *Due to germs*
   b. *Due to bad habits*
   c. *Due to the curse of God*

2. What is the best method of treating the bacterial infections?
   a. *Use of antibioticsa.*
   b. *Use of dhami jhhakri (traditional faith healers)*
   c. *Use of proper food and rest*

3. Antibiotics are powerful medicines that help to fight?
   a. *All diseases caused by infections*
   b. *All diseases caused by viruses*
   c. *All diseases caused by bacteria*

4. Antibiotic resistance happens when my body become resistant to antibiotics.
   a. *True*
   b. *False*

True or False? Ask the group whether each statement is true or false.

5. Antibiotic resistant bacteria can spread to humans through:
   a. *Contact with a person who has an antibiotic resistant infection*
   b. *Contact with an object that has been touched by a person who has an antibiotic resistant infection (e.g. a health worker's hands)*
   c. *Contact with a live animal, food or water carrying antibiotic resistant bacteria*
   d. *All of the above*

6. What can happen if I get an antibiotic-resistant infection?
   a. *I may be sick for longer*
   b. *I may have to visit my doctor more often to be treated in hospital*
   c. *I may need another stronger antibiotic which could be more expensive*
   d. *All of the above*

7. I can help tackle antibiotic resistance if I:
   a. *Share my antibiotics with my family if they are sick*
   b. *Get antibiotics as soon as I feel sick- either directly from a pharmacy or a friend*
   c. *Keep my vaccinations up to date*

8. Antibiotic resistance is already out of control and its only getting worse. There is nothing I can do.
   a. *True*
   b. *False*

WORKSHOP 2 - ACTIVITY 2: SHOOTING B-ROLL, 5 SHOT SEQUENCE AND INTERVIEWING WITH NEW TECHNIQUES

To introduce the group to the importance of B-Roll and 5 shot sequence in telling the story of an interview; to improve interview technique; to help the group to reflect further on the learning and sharing on how to make the films more interesting and effective

65 minutes (25 minutes for power point presentation on B-Roll and 5 Shot Sequence and remaining 40 minutes for interviewing with new techniques)

Projector, computer with power point presentation+ sample interview footage.

Short lecture followed by learning by doing, reflection and discussion.

Group sit around projector to start. 3x film equipment sets across the room

Capture the activity and document the process for evaluation

F1 Running/Explaining the activities. F1 to keep the mood light

F2 responsible for documentation (film, notes, stills...)

PROCESS

- F1 takes the group through the 3 versions of an interview
  - Raw footage, with too much information.
  - Rough cut, with ugly jump cuts but no interviewer voice.
  - Final polished version with titles and cutaways to hide jump cuts.
- Group discusses the process of polishing an interview video.
  - Further reflection on the types of questions that work best.
  - Further reflection on the relationship between interviewer and interviewee.
  - Discuss what is meant by 'b-roll'.
  - How best to ensure that you get all the 'b roll' footage you need (e.g. have one member of team note down the main points mentioned in an interview, so that the group can shoot relevant 'b roll').
- Discuss what else one might use as cutaway footage (diagrams/photos/video from the internet, short reenactments of scenarios discussed in the interview etc.).
  - Group discuss documentaries they have seen. F1 to potentially show some clips from particularly effective documentaries and to encourage the group to watch others/watch the television news with a critical eye to see how they present interviews.
- Whole group discusses important questions that have arisen from the previous activity about general drugs and antibiotics use and misuse
  - Group breaks into their smaller groups and decides upon one issue that they, as a group would like to discuss further.
  - They decide on a list of questions and carry out 1-2 interviews with each other.
  - One member of the group acts as a rapporteur and makes a note of what the interviewee talks about and what kind of b roll the group needs for their interviews.
  - The group goes off and shoots appropriate B-roll (to neighboring spaces of workshop hall considering the feasibility), following the 'rules' set out in the introductory lecture (shoot each image for at least 10 seconds etc.).

- F2 introduces the group to the '5 shot sequence'. As per the introductory power point presentation, this is a sequence of 5 shots (and an interview) that when cut together always present an activity in an interesting way (see Appendix 3)
    - Groups go off and shoot a 5 shot sequence (to neighboring spaces of workshop hall considering the feasibility) connected to an aspect of general drugs and antibiotics use and misuse they have discussed.
- As homework, each person in the group is asked to think about 2-3 different issues they would like to make films about. They won't necessarily make these films. This is just about getting them started thinking about the process. They shouldn't get too invested in these ideas! As the film(s) they make will be a joint endeavour.
    - What would these films look like?
    - What would they need to shoot?
    - Who would they need to interview/talk to?
    - What issues might they face in making these film?
    - What do they hope to achieve in making each of these films?

WORKSHOP 4: CONSOLIDATING KEY CONTENT AND IDENTIFYING THE KEY LOCAL STAKEHOLDERS

WORKSHOP 4 - ACTIVITY 1: MIND-MAPPING (LOCAL CONTEXT)

To consolidate our shared knowledge of the key actors and their role within the community to play in tackling general drugs and antibiotic misuse

30 minutes

Large piece of paper, pens

Collective mind-mapping and then sharing of WHO guidance.

Paper on wall in a prominent position, and all participants standing, with pens

Capture the activity and document the process for evaluation

F1 Facilitating the discussion and explaining the activity

F2 Ensuring all participants have an opportunity to engage

PROCESS

Set Up and Quick Review of Workshop 3 and today's activities (15 minutes)

Mind Mapping (30 minutes)

- F1 can explain that we are going to create a collective mind-map of the local stakeholders that we can think of who are engaged in any way with the issue of general drugs and antibiotic misuse. This might be because they are part of the cause, or part of the solution, or both. We are also going to probe what we think they should be doing in order to control general drugs and antibiotic misuse.
- F1 can explain that we will create this mind-map on a large piece of paper, showing who the stakeholders are, and how we think they are / could be engaged with the issue of general drugs and antibiotic misuse.
- F1 to ask for volunteers to write on the paper key stakeholders within the community, and what the actions are that they think they a. are taking place that fuel general drugs and antibiotic misuse, and b. ought to be taking in order to tackle antibiotic misuse.
- The stakeholders could be written in one colour, and the actions in two other colours (those that they are taking, and those that they ought to be taking). Lines can be drawn between the two, because several types of stakeholders might be engaging in similar actions.
- Note, the participants may not be able to identify very many, so the facilitator can probe: eg. Healthcare Professionals (doctors; nurses; midwives; dentists; others – public and private – pharmacists); Informal providers; Vets, Agro-vets, VAHWs, Farmers; Individuals)
- When the group can no longer think of any more, the facilitator can introduce the global organization, the World Health Organization that has produced guidelines for all countries to try to implement – move on to next exercise.

- F2 introduces the group to the '5 shot sequence'. As per the introductory power point presentation, this is a sequence of 5 shots (and an interview) that when cut together always present an activity in an interesting way (see Appendix 3)
    - Groups go off and shoot a 5 shot sequence (to neighboring spaces of workshop hall considering the feasibility) connected to an aspect of general drugs and antibiotics use and misuse they have discussed.
- As homework, each person in the group is asked to think about 2-3 different issues they would like to make films about. They won't necessarily make these films. This is just about getting them started thinking about the process. They shouldn't get too invested in these ideas! As the film(s) they make will be a joint endeavour.
    - What would these films look like?
    - What would they need to shoot?
    - Who would they need to interview/talk to?
    - What issues might they face in making these film?
    - What do they hope to achieve in making each of these films?

WORKSHOP 4 - ACTIVITY 2: CRITICAL REFLECTION ON WHO GUIDANCE

To critically reflect on the enablers and barriers to following the WHO guidance at community level.

55 minutes

Large piece of paper, with the guidance for individuals (also in relation to animals) written on it.

Critical discussion

Paper on wall in a prominent position, and all participants standing, with pens

Capture the activity and document the process for evaluation

F1 Facilitating the discussion and explaining the activity

F2 Ensuring all participants have an opportunity to engage

PROCESS

- Take each statement within the WHO guidance (for full guidance see p. 17-18) e.g. "Only use antibiotics when prescribed by a certified health professional".
- The first four statements from Individual guidance could be given priority since they are about individual behaviour and choice. Also, they could be discussed first since they are simple and lots of discussions have been made in previous workshop activities. Depending on nature of participants and time availability, facilitator can discuss other statements.
- Unpack the statement to ensure it is properly understood (e.g. who is a certified health professional in this setting). Note, that it is also interesting to learn if people do actually understand the statement. Critically discuss questions of what, who, and why i.e. what do people actually do (we probably already have a good idea by now, e.g. that perhaps they go straight to a pharmacy, or borrow from a friend), unpack who does what e.g. is it different in the case of children, or males, or females; and unpack why people tend to do certain things.
- This discussion then feeds into a discussion about possible solutions, building on the conversation that will have developed over the previous workshops. 'So what might help this to happen?' 'How could the guidance be rephrased to make it more helpful to people?' How do you think pharmacists/farmers/other gate keepers in your community might view this guidance?'
- The remaining statements for this exercise are:
  - Never demand antibiotics if your health worker says you don't need them.
  - Always follow your health worker's advice when using antibiotics.
  - Never share or use leftover antibiotics
  - Prevent infections by regularly washing hands, preparing food hygienically, avoiding close contact with sick people, and keeping vaccinations up to date.
  - Prepare food hygienically, following the WHO Five Keys to Safer Food (keep clean, separate raw and cooked, cook thoroughly, keep food at safe temperatures, use safe water and raw materials) and choose foods that have been produced without the use of antibiotics for growth promotion or disease prevention in healthy animals.
- At the end of this process, we hope that our participants are developing their own understanding of antibiotic misuse and what might be driving resistance in their own community. This should help them to develop the scripts and plans for their own films.

As many of the community members involved in the CARAN project were also closely linked to the agriculture sector, we contracted an agriculture expert to provide the following additionl guidelines for the agricultural community:

ADDITIONAL AGRICULTURAL COMMUNITY GUIDANCE

- Use of antibiotics in the feed should be strictly regulated and discouraged and monitored with check-ups and surveillance.
- Only give antibiotics to animals under veterinary supervision and withdrawal period should be strictly adhered to.
- Not using antibiotics for growth promotion or to prevent diseases in healthy animals and birds.
- Vaccinate animals to reduce the need for antibiotics and use alternatives to antibiotics when available.
- Promote and apply good practices at all steps of production and processing of foods from animal and plant sources.
- Improve biosecurity on farms and prevent infections through improved hygiene and animal welfare.

WORKSHOP 4- ACTIVITY 3: REFLECTION AND DISCUSSION OF THE INTERVIEW FOOTAGES FROM WORKSHOP 3

To showcase footage taken in workshop 3; To review and provide feedback on techniques and issues in the footage

20 minutes

Projector, HDMI cable, computer with participant footage

Film screening and Group discussion

Participants sit facing the projector screen

Capture the activity and document the process for evaluation

F1 reflects interview footage via the projector and documents via notes

Facilitating the discussion

PROCESS

F1 can explain that we are going to review/reflect on the footages that participants had captured in workshop 3. This might be useful while delivering feedbacks to participants on techniques and issues in the footage. For this, the participants are requested to express how they felt the things went pre, during and post interview/s.

WORKSHOP 4: DEVELOPING YOUR FILM IDEAS

SCRIPTWRITING, LOGLINES, FILM TREATMENTS & SHOOTING SCRIPTS

To develop the concept, to plan their films and to produce an outline shooting script.

120 minutes

Projector, computer with power point presentation, projector screen, Paper and pens to make notes

Critical discussion

Chairs around projector to begin followed by spaces for group work

Capture the activity and document the process for evaluation

Facilitating the discussion and explaining the activity

Ensuring all participants have an opportunity to engage

PROCESS

Set Up and Quick Review of Workshop 3 and today's activities (15 minutes)

Power Point Presentation on Scriptwriting (15 minutes)

- F1 runs through the 'Film Treatment, Shooting Script and a List of all Shots/Shot-division' Power point presentation introducing the participants to: Film title, film topic, story, characters, settings and key questions.
- A sample presentation is available on the CE4AMR website.

Developing your logline and film treatment (30 minutes)

- In 3 small groups, participants discuss the film ideas that they generated after Workshop 3, revisiting these in the light of the subsequent discussions and their improved understanding of community attitudes to general drugs and antibiotics misuse. The discussion is monitored and guided by F1. Over the course of the conversation, each group decides on a final concept for the film they want to make. It is important that each group chooses a different topic. This can be organized and monitored by F1.
  - What will the film be about? What is the question they want to ask?
  - Who is this film for? (audience)
  - How long should the film be? (F1 should explain about internet films and the need to keep them short- 3-6 minutes is a long time on the internet, and this is perhaps what people should be aiming for)
- Each group then comes up with a 20 second description of their film, which they have to 'pitch' to the other groups to get feedback on the core idea.
- After receiving feedback on their 'pitch', each group then start to develop their ideas further, producing a 'film treatment' (or overview) or their story, using the form in Appendix 4. They should think about the shape of the film using the structure below.

FILM TREATMENT TEMPLATE

Film Title	This should be catchy!
Film Topic	The general concept of a film
Characters	The people (or places or things) that drive the story.
Settings	The locations of the story.
Key Questions	The purpose or essential issue that the film seeks to address.
STORYLINE	The narrative arc of a film. Even documentaries still need an overall 'story'.
Introduction	Where the setting, theme and the characters are presented and developed.
Complication	Where the crucial 'problem' that the characters are facing is presented.
Climax	Where the action or drama peaks and/or the complication becomes most intense.
Resolution	Where the complication is resolved (not always successfully) and reflected upon.

(with thanks to REEL Lives Youth Media Education- http://www.reel-lives.org)

Writing your shooting script (60 minutes)

- Once groups have their 'film treatment', they then need to produce a 'Shooting Script'. This is a list of the shots that they will need to make their film.
- Groups can start by brainstorming against the following list of questions:
  - Who will they need to interview and why?
  - What questions will they need to make sure they cover in the interviews?
  - What things will they need to film? What will they need to shoot in their b-roll?
  - What kind of sound track will you have?
  - Do you need a voice over?
  - Will you have a 'presenter' to introduce the topic?
  - Who in the group will do what (camera? Director? Sound? Interviewer? Person who makes a note of what is said in the interviews- so that you know you have all the 'b-roll' shots you need).
- Groups should then produce a list of all the shots they imagine they will need. The groups then make a plan, with the facilitators, about how they are going to shoot their films. F1 should make clear that this shot list needs to be a 'live document', as it will change as new ideas occur to the group as different issues emerge during the interviews.

MAKING THE FILMS

SHOOTING THE FILM

- **Shooting Footage**
- **Reflecting on the footage as a group**
- **Shooting further footage based on the reflection**

PROCESS

- Each group will shoot their films over 3-4 days.
- If groups are aiming to make a 3-6 minute film, they will probably not need more than 4 interviews. They will probably interview people from between 10-20 minutes each, depending on how well the interview is going. They will only use a short extract from the interviews, but other information might well help to shape the overall film.
- F1 will meet each group individually every day to check if there is any confusion and help them if needed. S/he will also be in contact with the groups throughout in case they get into difficulty.
- On the 2nd day, all three groups will come together to reflect on the footage they have taken.
- All the footage will be transferred to a laptop so that everyone can have a look and suggest areas for improvement and the issues missing and so they can learn from each other's footage and that new ideas can emerge.
- Footage will be analyzed in groups and any shots that seem to be missing will be identified.
- Groups will establish what footage they still need to get. This could be footage that was already listed in the shooting script or something that has emerged during the filming process.
- Any difficulties they have been facing while filming will also be discussed and orientation will be provided to further help them with filming.
- The footage will also be technically analyzed during the meeting, in order to help participants to improve. They could also reshoot footage, if they like and if is possible
- All the footages from the individual groups will be collected after the 4th day in order to start the editing process.

EDITING THE FILM

- **Group reflection of footage**
- **Creating a paper edit**
- **Creating a rough cut**
- **Reflecting on the rough cut**
- **Undertaking additional shooting**
- **Producing a final cut**
- **Reflecting on the final cut**

PROCESS

- Each group's film will be edited over two days. This means that one group will be contacted at a time and the below mentioned activities will be conducted.
  - F1 will discuss with each group the reason for taking a particular piece of footage, or the story behind the footage.
  - An initial cut of all the footage will be undertaken. This is so that the group has a good overview of what footage they have, and to remove obviously bad footage that can't be used.
- The group will then create a rough 'paper edit' of the film:
- This will help them to think through the overall film, referring to their shooting scripts, but including further ideas that have developed over the shoot.
- A further cut of the footage will be undertaken, as a group, getting rid of footage that will obviously not make it to the rough cut.
- **Creating a rough cut:** Assemble the relevant footage as planned in the paper edit, in order to produce a rough cut of the film.
- **Reflecting on the rough cut:** Discuss with groups if the rough cut reflects what they had envisioned. If not what changes needs to be made or any other suggestions. The group to discuss what else they need to include (voice over? Cutaways? Other relevant images from the internet?)
- **Undertaking any additional shooting if required:** Discuss if they would like to do any additional shootings after having a look at the rough cut. FI will them give them a day to take the additional shots.
- **Selection of background music, titles, credits and other**
- **Producing a final cut:** A final cut will be made, assembling all the additional footages, also incorporating suggestions from the participants.
- **Reflecting on the final cut:** A final cut will be shown to the participants and their suggestions will be incorporated if needed. A final cut will then be ready for showcasing in the community incorporating all the suggestions.
- After the final cut of all three groups is ready, it will be shown to all group members together, and further feedback will be solicited.

PUBLIC SCREENINGS OF FILMS

- **Screen films to the participants**
- **Organise initial community screening**
- **Further participatory discussion with the community.**

The public screenings should be co-devised with participants as part of the advocacy campaign and will differ widely based on context. You can see a more detailed plan of how we did this in the following section.

Discuss with your partners and participants:

- Appropriate venue, date and time
- Structure of the event
- Who they want to invite (refer back to mapping and stakeholder activities)
- What are the best ways to advertise the event with their neighbours etc.?
- Order of films to be screened, who will introduce them etc.
- It's important to encourage them to think about why they want to host the event, what they want to achieve and how they will do it. Audience is key.

MONITORING & EVALUATION

WAYS OF COLLECTING DATA

- **Visual evaluation tools during workshops**
- **Focus Groups and Semi-Structured interviews to reflect on the process**
- **Engaging with public and stakeholders to gauge the films' impact**

PROCESS

- All activities should be filmed for the purposes of Monitoring and Evaluation, with the understanding that footage can only be used in any project outputs (e.g. a project 'making of' documentary, or in research outputs), with the permission of participants. Workshop footage should then be enhanced by a series of focus group interviews.
- Focus group interviews can be conducted alongside filmscreening/showcasing events. Further, Semi-Structured Interview (SSIs) can be also conducted with local-level stakeholders for evaluating the participatory approach/the study's findings. People to engage might include the mayor, deputy mayor, ward chair, ward member and so on.
- We encourage you to use your own established monitoring and evaluation methodologies that are most relevant to your needs for the project. If you would like to know more about the tools that were used for the CARAN project, please contact us: ce4amr@leeds.ac.uk

CARAN ADVOCACY WORKSHOP APPROACH

Stakeholders have been involved in CARAN to support the project development, implementation and output including policy development. We have engaged with stakeholders in order to achieve this as well as taking an advocacy approach to then get the relevant policy-makers on board to ensure that CARAN's outputs are used for policy development.

We engaged with relevant stakeholder's right from the outset of the project and fostered these relationships during the project implementation period, thus taking an integrated approach to health systems strengthening. Stakeholder management engagement and advocacy work will be conducted at three levels: national, local and community.

IDENTIFYING POTENTIAL STAKEHOLDERS AND SENSITIZATION

The stakeholders for the study were identified both prior to as well as during the project implementation. An initial mapping exercise was conducted by the project team to identify all the potential stakeholders. The mapping was informed by the current knowledge of the team members about different potential stakeholders, use of the HERD International network based on its experience of working in the area of AMR in the past as well as use of the snowballing technique. Since the scope of ABR is beyond the health sector, potential actors, and influencers of sectors other than health were considered.

NATIONAL LEVEL STAKEHOLDERS

Policy level stakeholders from:
Ministry of Health/ Departments of Health
Nepal Health Research Council
Ministry of Agriculture, Land Management and Cooperative
Nepal Agriculture Research Council
Department of Livestock
Ministry of Education
Ministry of Population and Environment
Labs (National Public Health Lab, Central Vet Lab)
Department of Drug Administration (DDA)
AMRCSC
Academic Institutions
GARP
Professional councils (Medical, Paramedics and Pharmacy)
Professional Societies (Nepal HA, Nepal Public Health Associations, Public Health Physicians, Pharma Associations)

Commercial Sector
Pharmaceutical societies
Poultry Associations
Drug Distributors/ Retailer and Wholesaler
Private Health Sector (Nursing Homes, Private Hospitals, Private Clinics)
Development Partners (WHO, FAO, DFID, Fleming Fund, OIE
Media (Filmmaking Industry, other National and International Medias)
Academic sector:
Representative from Agriculture and Forestry University
Representative from Himalayan College of Agriculture Science and Technology
Agriculture/vet faculty of IAAS/TU

LOCAL LEVEL STAKEHOLDERS

Mayor
Deputy Mayor
Chief Executive Officer
Identified Officials from Municipality office
Identified Officials from Ward Office (Ward Chair)
Social Workers

COMMUNITY LEVEL STAKEHOLDERS

Health Workers at various levels (Private and Government)
Traditional medicines (Ayurveda and homeopathy)
Female Community Health Volunteers
Pharmacy
Poultry farms
Informal service providers (Quacks, Traditional Healers, Spiritual healers)
Community Based Organisation
Informal Community Based Group
Community Forums (water, agriculture, forests, co-operatives)
Household (Users or non-users)

Prior to conducting the field activities, the team also coordinated with the local-level stakeholders, particularly the municipality and the respective ward level officials. During this process, we sought to explore and understand various local stakeholders relevant for the study and how best to approach them.

Community-level stakeholders were identified during the implementation of the project activities by the community members themselves. During the course of project implementation (particularly during the participatory activities, script development and film making) the group identified stakeholders at the community level.

Sensitization

The identified stakeholders at the national and the local level were sensitized about the objectives, processes, expected outputs of the project and their potential probable role. This sensitization was done either in the form of a structured formal meeting or through various. A short introductory film was developed and uploaded to the HERD Int's website. This was also used as a tool to inform the intended audience about the details of the project.

Periodic Update of the Progress of the Project:

In order to keep the stakeholders on board, we periodically updated them about progress in the project. HERD Int also used the opportunity in various national and subnational platform/ meetings to inform the stakeholders about the project. The HERD Int website was also used to note project progress and for wider dissemination.

Intersectoral Collaboration for Video Development:

We collaborated with various in-country experts in the area of AMR to develop a video to highlight the wider issues around ABR. HERD Int used its existing network to identify journalists and TV anchors to discuss how the project could engage national media.

ADVOCACY AT THE COMMUNITY, LOCAL & NATIONAL LEVEL

The stakeholders for the study were identified both prior to as well as during the project implementation. An initial mapping exercise was conducted by the project team to identify all the potential stakeholders. The mapping was informed by the current knowledge of the team members about different potential stakeholders, use of the HERD International network based on its experience of working in the area of AMR in the past as well as use of the snowballing technique. Since the scope of ABR is beyond the health sector, potential actors, and influencers of sectors other than health were considered.

COMMUNITY LEVEL

During the course of the project, various films were co-produced by the workshop participants in the selected communities in the area of ABR, engaging with what they believe and perceive to be important relevant issues for them. Since raising awareness about ABR and knowledge translation about ABR is an integral component of the project, the aim was for workshop participants to become advocates for raising awareness about ABR in their communities. Although only a small number of participants were actively engaged in filmmaking, the project also was able to raise awareness more broadly in the community in issues around ABR.

LOCAL LEVEL

An advocacy campaign was conducted at local level. This was supported by showcasing the films developed by the communities. The films were screened to key stakeholders from the municipality, including the Mayor, Deputy Mayor, Chief Executive Officer and other relevant officials from the municipality, key officials from the respective wards of the study sites and other people from the community as identified by the workshop participants/community people. All the people involved in the film making were also be invited for the film showcasing in the communities. Community members were central to these events, presenting films to local level officials, making posters and pamphlets and appearing on local FM radios.

The entire process and management of the filmmaking and subsequent advocacy was led by workshop participants, with HERD International supporting them as required. Community members were encouraged and supported to coordinate with the ward and municipality representatives themselves. They discussed and decided on the date and the venue for the showcasing. Also, they were given the liberty to invite as many participants as they wished. The team then logged the number of people attending the events.

NATIONAL LEVEL

At the end of the project, advocacy turned to the national level, with the project films being used to engage the Nepali Ministry of Health and Population and other relevant national-level stakeholders. The aim of this event was to ensure that the project's findings informed the national AMR action plan. This was the culmination of a series of meetings and dissemination events where the project team regularly project outputs (project briefs, research briefs, videos and blogs) to keep all stakeholders informed of progress.

APPENDIX 1: INFECTION PREVENTION GUIDANCE FOR FILM MAKERS

When making the films, participants may choose to visit areas of their community that bring them into contact with animals, animal products and/or farm workers. Certain infections in animals can cause disease in humans. For example, rabies or avian influenza.

By following these simple steps, you can minimise the chances of you catching these types of infections:

- Consider whether it is necessary for to visit these locations
- Are you up to date with your vaccinations such as tetanus, for Japanese encephalitis and rabies?
- If you are pregnant or immunosuppressed then it may be safer for you not to visit

If you are able to visit, take the following precautions when visiting sites:

- Cover cuts/grazes
- Avoid direct contact (touching, stroking) with all animals (well or unwell)
- Avoid animal bites, scratches or kicks (especially dogs, bats, monkeys)
- Avoid touching your nose, mouth or eyes
- Avoid contact with animal environments such as cages, walkways, fences or gates.
- Wash hands with soap and hot water after visiting sites; before smoking, touching your eyes or drinking; and before preparing or eating food
- If soap and water are not available then use antimicrobial handgel or similar but ensure wash hands with soap and water ASAP
- Do not drink or eat on the site
- Wear long clothes and use insect repellent to minimise risk of mosquito/sandfly bites
- Wear shoes that can easily be cleaned
- Clean shoes before entering and after leaving a site (using disinfectant)

If you come into contact, do the following:

- If bitten by a dog, bat or monkey, seek immediate medical attention
- If bitten, scratched or kicked by any other animal then prevent infection by washing wounds with soap and warm water immediately.
- Seeking medical attention if:
    - The animal appears sick or is acting unusual.
    - The wound or injury is serious (uncontrolled bleeding, unable to move, extreme pain, muscle or bone is showing, or the bite is over a joint).
    - The wound or site of injury becomes red, painful, warm, or swollen.
    - It has been more than 5 years since your last tetanus shot.
- If you become unwell in the subsequent 21 days then seek healthcare advice.
- Ensure you mention that you have visited sites containing animals, animal products and farm workers.
- If any bitten etc or subsequent ill-health occurs then please inform your contact at HERD International.

APPENDIX 2: GUIDANCE FOR MANAGING RISK TO STAFF FROM ZOONOTIC INFECTIONS DURING FIELDWORK

PURPOSE AND SCOPE

This document was developed for team members (HERD International and University of Leeds) involved in the CARAN project who are visiting sites containing animals, animal products and farm workers. It provides guidance to minimise risk specifically from infections that can be transmitted from animals to humans; either through direct contact or through food, water or the environment; and cause human disease ('zoonoses'[1]). It does not consider personal safety or other potential fieldwork risks (HERD International has a process for examining these risks for every fieldwork activity).

[1] 'Zoonoses' is the plural, 'zoonosis' is the singular

BACKGROUND

The CARAN project involves community participatory videomaking to develop community-led solutions to issues around antibiotic misuse and antibiotic resistance in Nepal. Research sites include urban and peri-urban areas. As part of this project, research team members may visit field sites that bring them in contact with animals, animal products and farm workers. As the research team have not been involved in this type of activity before, it was agreed that some guidance needed to be developed to minimise their risk of exposure to zoonotic infections.

ZOONOTIC INFECTION

Zoonotic infections can be caused by different types of infectious agent including bacteria, viruses, parasites and protozoa. The World Health Organisation lists 32 zoonotic diseases on their website[1]. However, many of these infections do not or rarely occur in Nepal. However certain diseases are known to occur in Nepal including:

Avian influenza	Fascioliasis
Brucellosis	Rabies
Leptospirosis	Zoonotic TB
Hydatidosis	Food borne infectious diseases e.g. Campylobacter, E.Coli
Cysticercosis	Mosquito or sandfly-borne infections e.g.
Dengue, Toxoplasmosis	Japanese encephalitis, leishmaniasis, Zika

More information on each of these diseases can be found in appendix 1 and at:
http://www.who.int/topics/infectious_diseases/en/

These zoonotic infections can be passed from animal to human in the following ways depending on the type of infection (See end of this document for more details):

- Direct or close contact with infected animals, their tissues or urine/faeces
- Indirect contact via contaminated surfaces e.g. touching bird cages, infected urine/faeces--contaminated environment
- Inhaling infectious agents e.g. as infected droplets or contaminated dust
- Eating contaminated animal products or food
- Drinking contaminated water
- Bite from an infected mosquito or sand-fly
- Exposure to saliva from rabies-infected animals (dog or bat) through a bite, scratch or lick on broken skin
- Contact exposure to uterine secretions of the aborted animals
- Consumption of raw un-boiled milk/milk products from infected animals

[2] http://www.who.int/zoonoses/diseases/en/

ASSESSMENT OF RISK

There is limited research, data or information on the incidence and prevalence of exposure and infections in Nepal. This makes it hard to assess the likelihood of possible exposure during fieldwork.

Furthermore, whether an individual develops an infection as a consequence of exposure is dependent on many factors including length/type of exposure, personal health including immunity, vaccination status etc.

Therefore, it is very hard to specifically quantify the risk that staff may be exposed to in the field. Consequently, this guidance will consider how to prevent such exposure, minimise exposure should it be necessary and how to manage exposure should it happen.

GUIDANCE TO PREVENT EXPOSURE TO INFECTIOUS AGENT WHILST VISITING FIELD SITES CONTAINING ANIMALS, ANIMAL PRODUCTS AND/OR FARMWORKERS

1) Prevention

This section focuses on actions that can be taken to prevent exposure to infectious agents whilst visiting field sites containing animals, animal products and farm workers.

Consider whether it is necessary for staff to visit sites that may expose them to potential zoonotic infection: Can the information be acquired in another way? Can the field work be done in an environment that prevents exposure? (e.g. somewhere else in the community)

Consider whether any vaccinations are appropriate:
- Vaccinations exist for Japanese encephalitis and Rabies (although immediate medical attention needs to be sought following exposure to possible rabies, even if vaccination has been given)
- Ensure up to date with tetanus vaccination

Consideration should be given as to whether a staff member is or could be pregnant or immunosuppressed as they are more at risk if exposed to infectious agents. In such a situation, consider deploying other members of staff.

2) Control

The section focuses on actions that can be taken to control and minimise exposure to infectious agents visiting field sites containing animals, animal products and farm workers is necessary.

- Check information resources to see whether there are or thought to be any higher risk of zoonotic infections occurring in Nepal e.g. an outbreak of avian influenza
- Nepalese Epidemiology and Disease Control Division – this is the division responsible for disease outbreaks in Nepal
- WHO disease outbreak news – the website provides advice about disease outbreaks internationally
- UK based travel and outbreak advice/information – this UK based website provides outbreak advice and information in Nepal

If higher risks then consider:

- postponing fieldwork
- performing fieldwork but in a safer environment (e.g. remote from fieldwork site)
- taking additional advice from local experts as to whether additional precautions are required

Take the following standard precautions [1] [2] [3] [4] [5] [6] [7]:
- Cover cuts/grazes
- Avoid direct contact (touching, stroking) with all animals (well or unwell)
- Avoid animal bites, scratches or kicks (especially dogs, bats, monkeys)
- Avoid touching your nose, mouth or eyes
- Avoid contact with animal environments such as cages, walkways, fences or gates.
- Wash hands with soap and hot water after visiting sites; before smoking, touching your eyes or drinking; and before preparing or eating food
- If soap and water are not available then use antimicrobial handgel or similar but ensure wash hands with soap and water ASAP
- Do not drink or eat on the site
- Wear long clothes and use DEET insect repellent to minimise risk of mosquito/sandfly bites [8]
- (Dengue, yellow fever, Zika, and chikungunya vector mosquitoes bite mainly from dawn to dusk; Malaria, West Nile, and Japanese encephalitis vector mosquitoes bite mainly from dusk to dawn).

[1]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322846/Farm_visits_avoiding_infection.pdf
[2] https://avmajournals.avma.org/doi/pdfplus/10.2460/javma.243.9.1270
[3] https://www.cdc.gov/healthypets/pets/farm-animals.html
[4] https://www.cdc.gov/healthypets/pets/wildlife.html
[5][5] https://www.cdc.gov/healthypets/pets/farm-animals/backyard-poultry.html
[6] https://www.cdc.gov/healthypets/pets/dogs.html
[7] https://www.cdc.gov/dengue/prevention/index.html
[8] https://wwwnc.cdc.gov/travel/yellowbook/2018/the-pre-travel-consultation/protection-against-mosquitoes-ticks-other-arthropods

Take the following additional precautions [9]:
- Only wear shoes at the field site that can easily be disinfected
- Disinfect shoes before entering and after leaving a site

[9] https://www.gov.uk/guidance/avian-influenza-bird-flu#biosecurity-advice

For larger farms e.g. over 500 chickens, more extreme biosecurity precautions [10] should be considered such as:
- Disinfecting all equipment
- Wearing gloves, protective outer-clothing and masks (Personal Protective Equipment, PPE)
- However, this is likely to create barriers both physically and psychologically between the research team and community and the appropriateness of the visit should be reconsidered or specialist advice sought.

3) Managing exposure

This sections focusses on what to do if exposure occurs during or after visiting field sites containing animals, animal products and farm workers.
- If bitten by a dog, bat or monkey, seek immediate medical attention
- If bitten, scratched or kicked by any other animal then prevent infection by:
    - Washing wounds with soap and warm water immediately.
    - Seeking medical attention if:
        - The animal appears sick or is acting unusual.
        - The wound or injury is serious (uncontrolled bleeding, unable to move, extreme pain, muscle or bone is showing, or the bite is over a joint).
        - The wound or site of injury becomes red, painful, warm, or swollen
        - It has been more than 5 years since your last tetanus shot.

If you become unwell in the subsequent 21 days then seek appropriate healthcare advice. Ensure you mention that you have visited sites containing animals, animal products and farm workers.

[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/674627/ai-prevention-zone-180118.pdf

4) Subsequent actions

This section focusses on actions that should be taken during or after the fieldwork. If any exposure or ill-health occurs then:

- The Principal Investigator and HERD International team must be informed immediately in order to ensure:
- Appropriate medical care is provided to the team member
- The fieldwork and guidance is reviewed to prevent further incidents
- The appropriate Public Health Team (and other agencies) in Nepal are informed of the incident
- Appropriate documentation (such as a significant event form is completed)

The field team should reflect on the field work to identify whether any changes need to be made to the guidance or processes to ensure that exposure is prevented or minimised in future fieldwork. Ensure appropriate and safe disposal of any PPE.

5) Zoonotic infections that may present in Nepal and mode of spread:

Avian influenza flu ('bird flu')	Close contact with infected birds or their tissues; Indirect contact via contaminated surfaces e.g. touching bird cages; Inhaling airborne viruses e.g. as droplets or dust or contaminated dust
Brucellosis	Direct contact with infected animals; Contact with uterine fluids of aborted animals; Eating or drinking contaminated animal products; Inhaling airborne agents
Leptospirosis	Direct contact with the urine of infected animals or with a urine-contaminated environment (e.g. water).
Hydatidosis	Ingestion of soil, water or food (e.g. green vegetables, berries) contaminated with the cysts of the parasites; Hand-to-mouth transfer of eggs after contact with the contaminated fur e.g. a dog
Cysticercosis	Ingestion of parasite cysts from raw/undercooked pork
Toxoplasmosis	Ingestion of cysts from undercooked food Exposure to infected cat faeces
Fascioliasis	Consuming larvae-contaminated uncooked vegetables/salads grown in marshy areas or drinking larvae-infected water
Rabies	Saliva from an infected animal (dog or bat) through a bite, scratch or lick on broken skin; Bite of infected bats
Zoonotic TB	Eating contaminated food; Airborne transmission; Drinking unboiled/unpasteurized milk produced from infected animals
Food borne infectious diseases e.g. Campylobacter, E.Coli	Ingestion on contaminated food, Water
Mosquito or sandfly-borne viruses e.g. Dengue, Japanese encephalitis, leishmaniasis, Zika	Bite from infected mosquito or sandfly

Additional References:
http://documents.worldbank.org/curated/en/203131468059704553/pdf/ICR32600ICR0P10C0disclosed010020140.pdf
http://www.ansab.org/uncategorized/one-health-asia-programme-ohap-fighting-zoonoses-in-afghanistan-bangladesh-and-nepal/

APPENDIX 3: A 5-SHOT SEQUENCE

1

CLOSE UP OF THE HANDS

An intriguing intro to the sequence. What's happening here?

2

CLOSE UP OF THE FACE

Who is this person? You can cut off the top of the person's head to get in close, but make sure you feature the eyes.

3

POINT OF VIEW SHOT

Ah, they're about to take a tablet! The PoV shot puts us directly into the action.

4

WIDE SHOT

Where is this all taking place?
Who is this person?

5

AN UNUSUAL ANGLE

This is a good way to round the sequence off and to give another angle on the subject (here a low angle shot that empowers the subject).

APPENDIX 4: SELECTION OF CARAN FILMS

1

CARAN: AN OVERVIEW

https://www.youtube.com/watch?v=1ZoRY-4cEus

2

CARAN: PRETEST

https://vimeo.com/289052119

3

PARTICIPATORY FILMMAKING AND ANTIBIOTIC RESISTANCE 1

https://www.youtube.com/watch?v=W-R205-kudQ

4

CONNECTING THE COMMUNITY: CARAN FILM SHOWCASING 1

https://www.youtube.com/watch?v=rjblSdlfINE

https://www.youtube.com/watch?v=DOZCAO2NbWY

5

CARAN PARTICIPANTS' FILM 2

https://www.youtube.com/watch?v=GBZCunEPD3U

6

CARAN SHOWCASING FILM 2

https://www.youtube.com/watch?v=1LZ1LAoJfXg

Community Arts Against Antibiotic Resistance in Nepal
Facilitators' Manual

Version 1.1 published June 2019

All images featured are from the CARAN workshops and showcasing events 2018-19, featuring our project team, participants and showcase attendees from the Chandragiri municipality and the Lokanthali neighbourhood, both in Kathmandu, Nepal.

This guide is a living document and remains in development.
For the latest version please email ce4amr@leeds.ac.uk

Funders

Arts & Humanities Research Council

MRC Medical Research Council

GCRF Global Challenges Research Fund

Project Team

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